

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **GOVINDASAMY SANKAR, M.D.**

4 Holder of License No. 33633  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona

Case No. MD-10-1440A

**FINDINGS OF FACT, CONCLUSIONS  
OF LAW AND ORDER**

(Letter of Reprimand)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on  
8 June 8, 2011. Govindasamy Sankar, M.D. ("Respondent") appeared before the Board for a  
9 formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The  
10 Board voted to issue Findings of Fact, Conclusions of Law and Order after due  
11 consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

13  
14 1. The Board is the duly constituted authority for the regulation and control of  
15 the practice of allopathic medicine in the State of Arizona.

16 2. Respondent is the holder of license number 33633 for the practice of  
17 allopathic medicine in the State of Arizona.

18 3. The Board initiated case number MD-10-1440A after receiving a complaint  
19 regarding Respondent's care and treatment of a 60 year-old male patient ("CG") alleging  
20 that Respondent inappropriately prescribed CG controlled substances.

21 4. In March 2005, CG established care with Respondent's partner.  
22 Approximately four years later, in October 2009, Respondent assumed care of CG and  
23 continued his Methadone medication at a dose of 40mg with prescriptions provided on a  
24 monthly basis.  
25

1           5.     On January 2, 2010, CG sustained a fracture of the C3 facet without spinal  
2 injury and he was treated in the emergency room. Respondent later saw CG, referred him  
3 to neurosurgery and continued his Methadone prescription.

4           6.     CG was seen by neurosurgery, in which a repeat CT scan was conducted  
5 that showed healing of the C2-3 facet joint. Neurosurgery recommended a bone scan,  
6 which CG refused to schedule.

7           7.     On February 5, 2010, Respondent saw CG and refilled his Methadone.

8           8.     On March 8, 2010, CG had a syncopal episode and emergency medical  
9 services were contacted. He had a witnessed run of tachycardia with a decreased level of  
10 consciousness. CG was given Amiodarone followed by synchronized cardioversion and  
11 he was treated with defibrillation, Amiodarone, Magnesium, a Lidocaine Bolus and drip,  
12 and Lopressor.

13          9.     CG was admitted to the hospital under the care of Respondent and had a  
14 urine drug screen positive for THC and negative for opiates.

15          10.    An EKG showed SR with a prolonged PR and a RBBB. Respondent  
16 incorrectly documented CG's prescription information on his dictated history and physical  
17 and mistakenly stated that CG had undergone a coronary angiogram.

18          11.    Respondent ordered Methadone, daily Fluoxetine and Sorbitol. He did not  
19 address the abnormal drug screen results.

20          12.    The cardiologist noted a prior cardiac catheterization and planned for  
21 myocardial perfusion imaging and serial EKGs and enzymes. No cardiac catheterization  
22 was performed. CG's potassium was corrected and Lidocaine was discontinued. A  
23 Thallium stress test showed a large inferior defect, and a cardiac catheterization later  
24 showed normal coronary arteries. The cardiologist noted the false positive Thallium scan  
25 and recommended medical management and drug rehabilitation.

1           13. CG was discharged on March 13, 2010 and was advised to decrease the  
2 Methadone dose.

3           14. On March 29, 2010, Respondent saw CG with a complaint of burning during  
4 urination and a decreased urine flow. He prescribed Methadone and Ciprofloxin.

5           15. CG was seen in the emergency room requesting a refill of Methadone on  
6 July 13, 2010 and reported that he had changed physicians. CG saw Respondent a week  
7 later for a pain medication refill, and Methadone 10 mg #270 was prescribed. That  
8 evening CG went into cardiac arrest and was found pulseless and apneic with CPR in  
9 progress. CG was found to be in ventricular fibrillation and ventricular tachycardia. He was  
10 defibrillated and went into asystole. Resuscitation efforts were unsuccessful and CG was  
11 later pronounced dead in the emergency room.

12           16. The Medical Examiner opined that CG's death was due to Methadone  
13 intoxication, with Hepatitis C as a significant contributing factor.

14           17. At the Formal Interview, Respondent observed that the present case was the  
15 first complaint brought against him in nearly 34 years of practice. He also noted that the  
16 autopsy report on the patient pointed to morphine in his blood stream, but there was  
17 nothing in the pharmacy survey or the emergency room records from July 13 indicating  
18 where the morphine came from.

19           18. During their deliberations, members of the Board expressed concern with the  
20 inadequacy of Respondent's medical records as well as his deviations from the standard  
21 of care. Of particular concern was the fact that Respondent reinstituted the patient's  
22 Methadone without ascertaining the amounts and types of opiates that patient was on at a  
23 time when he had not seen the patient for three months. The Board concluded that  
24 Respondent's conduct had the potential to cause the harm that occurred to the patient.

19. The standard of care for managing a patient's chronic pain with Methadone requires a physician to address current pain medication use when the patient has not been prescribed Methadone by the provider in more than three months.

20. Respondent deviated from the standard of care by failing to ascertain the amounts and types of narcotic medications that CG had used for treatment of his pain while not receiving monthly Methadone from Respondent.

21. The standard of care requires a physician to address findings of an illegal substance on a urine drug screen with a patient who is receiving narcotics for chronic pain and who has previously signed a pain medication management agreement that states positive tests for any illegal substances will result in dismissal.

22. Respondent deviated from the standard of care by failing to address a urine drug screen that was positive for THC during CG's March 2010 hospitalization.

23. There was potential for Methadone overdose with cardiac arrhythmias including ventricular fibrillation and ventricular tachycardia.

## CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(e) (“[f]ailing or refusing to maintain adequate medical records on a patient.”).

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) (“[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.”).

1 ORDER

2 IT IS HEREBY ORDERED THAT

3 1. Respondent is issued a Letter of Reprimand.

4 2. Respondent shall, within six months, complete 15 hours of Board Staff pre-  
5 approved Category I Continuing Medical Education ("CME") in opioid prescribing and  
6 provide Board Staff with satisfactory proof of attendance. The CME hours shall be in  
7 addition to the hours required for biennial renewal of his medical license. Respondent's  
8 failure to complete the CME will subject him to future disciplinary action by the Board.  
9 A.R.S. § 32-1401(27)(r).

10  
11 RIGHT TO PETITION FOR REHEARING OR REVIEW

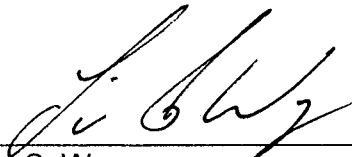
12 Respondent is hereby notified that he has the right to petition for a rehearing or  
13 review. The petition for rehearing or review must be filed with the Board's Executive  
14 Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The  
15 petition for rehearing or review must set forth legally sufficient reasons for granting a  
16 rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after  
17 date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed,  
18 the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

19 Respondent is further notified that the filing of a motion for rehearing or review is  
20 required to preserve any rights of appeal to the Superior Court.

21  
22  
23 DATED AND EFFECTIVE this 11<sup>th</sup> day of AUGUST, 2011.  
24  
25



ARIZONA MEDICAL BOARD


By   
\_\_\_\_\_  
Lisa S. Wynn  
Executive Director

6 EXECUTED COPY of the foregoing mailed  
7 this 11<sup>th</sup> day of August, 2011 to:

8 Paul Giancola  
9 Snell & Wilmer, LLP  
400 E. Van Buren  
Phoenix, AZ 85004  
(Attorney for Respondent)

10  
11 ORIGINAL of the foregoing filed  
12 this 11<sup>th</sup> day of August, 2011 with:

13 Arizona Medical Board  
9545 E. Doubletree Ranch Road  
Scottsdale, AZ 85258

14   
15 Arizona Medical Board Staff

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **GOVINDASAMY SANKAR, M.D.**

4 Holder of License No. **33633**  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Board Case No. MD-10-1440A

**ORDER DENYING MOTION FOR  
REHEARING OR REVIEW**

(Letter of Reprimand)

7  
8 At its public meeting on October 5, 2011, the Arizona Medical Board ("Board") considered  
9 a Petition for Rehearing or Review filed by Govindasamy Sankar, M.D. ("Respondent").  
10 Respondent requested the Board rehear or review its August 11, 2011, Findings of Fact,  
11 Conclusions of Law and Order for Letter of Reprimand in Case no. MD-10-1440A. The  
12 Board voted to deny the Respondent's Petition for Rehearing or Review upon due  
13 consideration of the facts and law applicable to this matter.

14 **ORDER**

15 IT IS HEREBY ORDERED that:

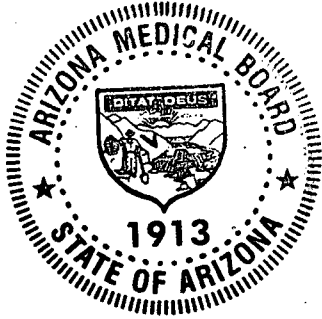
16 Respondent's Petition for Rehearing or Review is denied. The Board's August 11,  
17 2011, Findings of Fact, Conclusions of Law and Order for Letter of Reprimand in Case  
18 no. MD-10-1440A is effective and constitutes the Board's final administrative order.

19 **RIGHT TO APPEAL TO SUPERIOR COURT**

20  
21 Respondent is hereby notified that he has exhausted his administrative remedies.  
22 Respondent is advised that an appeal to Superior Court in Maricopa County may be  
23 taken from this decision pursuant to title 12, chapter 7, article 6 of Arizona Revised  
24 Statutes.  
25

1  
2 DATED this 17<sup>th</sup> day of October, 2011.

3  
4 THE ARIZONA MEDICAL BOARD



By *Lisa Wynn*  
LISA WYNN  
Executive Director

10  
11  
12  
13 ORIGINAL of the foregoing filed this  
14 *Lisa Wynn* day of October, 2011 with:

15 Arizona Medical Board  
16 9545 East Doubletree Ranch Road  
17 Scottsdale, Arizona 85258

18 Executed copy of the foregoing  
19 *Lisa Wynn* mailed by U.S. Mail this  
day of October, 2011 to:

20 Paul Giancola  
21 Snell & Wilmer, LLC  
22 One Arizona Center  
23 400 E. Van Buren  
24 Phoenix, AZ 85004-2202

25  
*Chris Bandy*